PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A re-certification survey was conducted from 12/04/2007 through 12/05/2007. A random sampling of two clients was selected from a population of three individuals with varying degrees of disabilities. This survey was conducted using the fundamental process. The findings of this survey were based on observations at the group home and two day programs, interview with direct care staff and management, and a review of the habilitation and administrative records including the unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility ' s governing body failed to enactment policies and procedures to ensure the provision of guardianship and to address client elopement. The findings include: 1. Staff interview on 12/6/2007 at 2:15pm revealed Client #2 was without the services of a court appointed guardian. The Qualified Mental Retardation Professional (QMRP) indicated that the facility has enacted measures to ensure this client be provided the services of a court appointed guardian or advocate. There was no documentation on file or presented during the time of survey to substantiate that the facility has taken the necessary proactive measures to	W 104	1. The ISP has been amended to reflect who individual #1 has identified to sign substituted consent concerning her health, medical needs, wellbeing and care. See Attachment # 1	

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 FEB 25 A 11:43

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-25-08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 1 provide this client with either an advocate or a guardian. [Reference W249] 2. Record review on 12/6/2007 at 2:20pm revealed Client #2 " eloped " from the facility twice over the past certification year. Further record review revealed there was no policy or procedures on file to govern the care and management of the situation of a client ' s elopement. Interview with the facility ' s QMRP on 12/6/2007 at 12:10pm revealed that the current policies do not address client elopement. There was no evidence on file or presented at the time of survey to substantiate that proactive and preventive measures have been put in place to ensure client safety with regards to the management of episodes of [client] elopement. [Reference W149]	W 104	2. Elopement is a targeted behavior for this individual, and it was reviewed at her psychotropic medication review on 3/22/07. An incident report was not completed for these behaviors because in this case the individual did not leave the premises nor were they out of eye sight of the staff at anytime. The agency policy address what needs to be done in the case of a missing person and what constitutes a missing person. See Attachment #2	2-13-2008
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure the provisions of this section prior to implementing a client ' s psychotropic medication regimen. [Client #1 & #2] The finding includes:	W 124		

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 2 1. Client #1 was observed being administered 400mg of Tegretol (for mental condition), 2mg of Klonipin (for mental condition), 5mg of Risperdal (for Psychosis) and 450mg of Lithium Carbonate (for explosive behavior disorder). Record review revealed this client ' s medications were administered as prescribed based on the current physician ' s orders (12/2007) that were on file. Interview with the facility ' s QMRP on 12/6/2007 at 1:56pm revealed that Client #1 ' s older sister has been actively involved in her care ever since she was committed. Further record review revealed, Client #1 ' s sister signed the " Informed Consent for Psychotropic Medication and Behavior Support " agreement, but there is no evidence that she took part in the Psychotropic Medication Review which was held on 11/29/2007 or the Human Rights Committee meeting to address the implementation of Client #1 ' s Behavior Support Plan. 2. Client #2 was observed being administered 400mg of Chlorpromazine HCL (for Psychotic Disorder) and 1mg Klopin (for Panic Attacks/Impulse Control). Record review revealed this client ' s medications were administered as prescribed based on the current physician ' s orders (12/2007) that were on file. Interview with the facility ' s QMRP on 12/6/2007 at 2:00pm revealed that Client #2 has not been appointed a legal advocate to date. Further record review revealed that no one stood as either a legally appointed guardian or advocate during the psychotropic medication review or the Human Rights Committee meeting to address the implementation of her Behavior Support Plan.	W 124	1. Individual #1's sister has been invited to her sister's psychotropic medication review and any HRC meetings that pertain to this individual. See Attachment #3 2. See W104 #1	2-23-2008 2-27-2008
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS	W 126		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 126	Continued From page 3 The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that client ' s were able to manage their finances as required by this section. [Clients #1 & #2] The finding includes: During the evening observations on 12/4/2007, staff indicated that Clients #1 and #2 were to take part in a shopping outing. They were to attend a local mall and make purchases for gifts to be given over the coming holidays. Interview with the facility ' s QMRP on 12/5/2007 at 2:32pm revealed the facility has accounts at a local bank under their names, but neither of them takes part in the depositing or withdrawal of their funds. According to the QMRP, the House Manager procures the funds from the facility ' s President/Owner after he withdraws the money from the client ' s accounts. Record review revealed neither Client #1 nor Client #2 had been assessed to determine their level of ability with regards to money management. There was no evidence on file or presented at the time of survey to substantiate that both client ' s had a been provided the opportunity to manage their finances to the best of their ability.	W 126	All individuals had a money management assessment completed on 10/20/07 to determine their ability to manage their money and subsequently active treatment programs were implemented based on the analysis of their individual assessments. See Attachment #4.	2-23-2008
W 141	483.420(b)(1)(ii) CLIENT FINANCES The facility must establish and maintain a system that precludes any commingling of client funds with facility funds or with the funds of any person	W 141		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	5634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 141	Continued From page 4 other than another client. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure clients were afforded the benefit of separately identifiable interest bearing accounts. [Clients #1 & #2] The finding includes: During the evening observations on 12/4/2007, staff indicated that Clients #1 and #2 were to take part in a shopping outing. They were to attend a local mall and make purchases for gifts to be given over the coming holidays. Interview with the facility ' s QMRP on 12/5/2007 at 2:32pm revealed the facility has accounts at a local bank under their names, but neither of them takes part in the depositing or withdrawal of their funds. According to the QMRP, the bank accounts are held under the facility ' s name, but each client ' s funds can be identified accordingly. There were no financial records available at the time of survey and as such, there was no means to ensure that each separate account accrued interest independently of each other per client.	W 141	Please note that the individuals financial records were available were available to be viewed at the time of the survey, however the severer did not review them at the site and requested that they be brought to 825 North Capitol Street the following day and the QMRP complied with this request, and upon the arrival at the specified location, the surveyer was not there to review the records. Additionally, all individuals do have interest bearing accounts a reputable financial institution and each person has their own account in their own name. Finance books are kept current by the house manager and reviewed by the administrator.	2-23-2008
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by:	W 153		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 5 Based on observation, staff interview and record review the facility failed to ensure a client ' s elopement was reported as required by this section for one of two sampled clients. [Client #2] The finding includes: Record review on 12/6/2007 at 2:20pm revealed Client #2 " eloped " from the facility twice over the past certification year. Staff documented that this client eloped twice on 2/27/07. The instances of elopement occurred at 4:36pm and again at 5:45pm on that same day. The first time she " eloped " from the facility, she stood on the porch. The second time she " eloped " from the facility; she went out to the street and sat on the sidewalk. As recorded, on both occasions, staff was able to coax her back into the home. The QMRP was interviewed on 12/6/2007 at 12:05pm and it was revealed that she was not aware Client #2 had eloped earlier in the year. She further added that there should have been an incident report generated because of the recorded events of elopement. There was no evidence on file or presented at the time of survey to substantiate that these documented incidents of elopement were properly reported as required by this section.	W 153	Elopement is a targeted behavior for this individual, and it was reviewed at her psychotropic medication review on 3/22/07. An incident report was not completed for these behaviors because in this case the individual did not leave the premises nor were they out of eye sight of the staff at anytime. The agency policy address what needs to be done in the case of elopement and what constitutes elopement. See Attachment #2	2-23-2008
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility ' s QMRP failed to ensure the coordination	W 159		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 6 of services to manage the implementation of programmatic measures to prevent a client ' s elopement; failed to address a client being assessed as a suicide risk; The finding includes: 1. During afternoon and evening observations on both 12/4/2007 and 12/5/2007, Client #2 was observed to independently manage her chores after staff prompted her to initiate each task. The various assignments took place at different parts of the house, on different floors, and oftentimes out of sight. Record review on 12/6/2007 at 2:20pm revealed Client #2 " eloped " from the facility twice over the past certification year. Staff documented that this client eloped twice on 2/27/07. Further record review revealed Client #2 ' s Psychology Assessment dated 8/23/2007 addressed her potential to elope with the following treatment recommendations: a. Goal: [Client #2] will decrease episodes of elopement to zero incidents per month. b. Intervention Strategies: " address elopement before it occurs by making certain that [Client #2] is supervised by staff at all times. If [Client #2] is successful in leaving her group home or other assigned area, staff should calmly pursue her (calmly, as to prevent further agitation) and ask her to return with them. If [Client #2] refuses, staff should use approved physical control techniques of CPI designed to escort a person from one location to another. If the situation continues to escalate, staff should call other [Provider] staff or the police for assistance. This client ' s Psychiatric Assessment dated	W 159	1. During the time of the elopement the individual referenced was under one to one supervision and the BSP regards elopement as running into the street, which this individual did not do in this case. And staff have been trained on what constitutes elopement and how to properly document such events. See attachment #5.	2-25-2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 7 9/13/07 further recommends: a. Continue to implement behavior support plan. Continue to emphasize following the proactive strategies outlined in the behavior program to avoid behaviors before they occur. b. Continue to monitor [maladaptive] behaviors. Further interview with the facility ' s QMRP revealed she was not certain what the Psychologist meant when she recommended Client #2 remain in her " assigned area ". In addition, she stated this client ' s one-to-one staffing was discontinued, but was not aware the psychologist had recommended this client be " supervised by staff at all times " and that staff should " pursue her " if she leaves her " assigned area ". There was no evidence presented or on file at the time of survey to substantiate that the necessary coordination of services was implemented to address this client ' s potential to elope. 2. Record review and interview with the facility ' s QMRP on 12/6/2007 at 1:35pm revealed that Client #2 may be a suicide risk based on the attending Psychiatrist ' s assessment. The QMRP was not aware of this finding and as such had not assessed the implications of this treatment recommendation. [Reference W212] 3. The QMRP failed to ensure the proper and necessary banking/money management provisions of each client. [Reference W141]	W 159	2. No statement of this nature is reflected in the psychiatric assessment, however the psychological assessment does recommend the implementation of the suicide behavior protocol which is filed in the individuals IPP book and it is recommended to by implemented as needed by the psychologist. 3. See W141	2-23-2008 2-23-2008
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the	W 189		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 8 employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each employee had been provided with adequate training to enable them to perform their duties effectively, efficiently and competently. The findings include: Record review on 12/6/2007 at 2:20pm revealed Client #2 " eloped " from the facility twice over the past certification year. Staff documented that this client eloped twice on 2/27/07. Record review also revealed that the attending Psychologist had addressed this need on 8/23/2007 by recommending a treatment strategy to prevent this client ' s elopement. There is no evidence that staff had been trained on how to manage, document and/or report this client ' s elopement. [Reference W149 & W153]	W 189	Staff have been trained on how to document, prevent, manage and this persons elopement, and what constitutes elopement.	2-25-2008
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the inclusion of a client ' s advocate in the creation of the Comprehensive Functional Assessment. The finding includes:	W 209		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 209	Continued From page 9 Record review revealed Client #1 has had Psychotropic Medication Reviews, Individual Program Plan meetings, Human Rights Committee meetings and an Individual Habilitation Plan meeting over the past certification year. There is no evidence that this client ' s sister has been notified or provided the opportunity to take part in these meetings. Interview with the facility ' s QMRP on 12/5/2007 at 1:56pm revealed Client #1 ' s sister has always taken an active role in providing care for her younger sister since her commitment. The QMRP could not explain or provide documented evidence to show why the sister has not taken part in the various meetings that took place throughout the year. There was no evidence presented or on file to substantiate that Client #1 has been afforded the opportunity of having her sister take part in her living plan.	W 209	See W124 #1	2-23-2008
W 212	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately assess a client ' s potential to attempt suicide. The finding includes: While reviewing how the facility managed Client #2 ' s episodes of elopement on the afternoon of 12/6/2007, it was found that Client #2 ' s Psychiatric assessment dated 9/13/2007 resolved that the facility should " Implement Reintegration	W 212		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 212	Continued From page 10 Plan and Suicide Behavior Protocol when needed " . A secondary review of the records with the QMRP ' s assistance revealed that there was no other instance of recording that this client was a suicide risk. It was also not clear how or why the Psychiatrist indicated as such. It was also not clear what the " Reintegration Plan and Suicide Behavior Protocol " entailed. The actual plan could not be located anywhere in this client ' s records. The QMRP indicated that she will address this finding to ensure the health and safety of this client.	W 212	No statement of this nature is reflected in the psychiatrist assessment, however in the psychological assessment dated 9/13/07 written by the psychologist does recommend the implementation of the reintergration plan and behavior protocol as needed which is filed in the individuals IPP book, and is recommended by the psychologist	2-23-2008
W 230	483.440(c)(4)(ii) INDIVIDUAL PROGRAM PLAN The objectives of the Individual program plan must be assigned projected completion dates. This LEVEL B is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure a client ' s programmatic intervention to manage elopement was designed with a targeted end date. [Client #2] The finding includes: 1. According to record review on 12/6/2007 at approximately 1:15pm, Client #2 ' s Psychologist assess her on 8/23/2007 and recommended the treatment goal of " Client #2 will decrease episodes of elopement to zero incidents per month " as a means of addressing this maladaptive behavior. The goal addresses the maladaptive behavior but, does not provide a targeted end date. As such, there is no measure of monitoring and/or re-assessment in place to assess the efficiency of the proactive strategies.	W 230	1. The psychologist will review the BSP of Client #2 to indicate a period of time as to when zero episodes of elopement per month should be achieved and when that behavior should be removed from the BSP.	2-28-2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 230	Continued From page 11 [Reference W159 and W189] 2. Observation at the facility and at Client #1 ' s day program on 12/4/2007 and 12/5/2007 revealed she requires consistent prompting to stay on task and appeared to tire quickly whenever engaged in any activity which required physical exertion. Review of Client #1 ' s programmatic record revealed her Nutritional assessment dated 3/6/07 recommends that the facility manage Client #1 ' s weight via the following treatment plan: a. Goal - " [Client #1] will improve her physical fitness skills " . b. Objective 3a - " [Client #1] will exercise for thirty minutes by doing an activity that elevates her heart rate with 2 verbal prompts for three consecutive months. c. Objective 3b - " [Client #1] will exercise for thirty minutes by doing an activity that elevates her heart rate with 1 verbal prompts for three consecutive months. None of the above programmatic objectives are presented with targeted end dates. As such, there is no timetable in place to accurately monitor the effectiveness of the programming plan and this client is steadily gaining weight. [Reference W249]	W 230	2. The objective has been revised the read that she will exercise for fifteen consecutive minutes in the AM and fifteen consecutive minutes in the PM by doing an activity of her choices that elevates her heart rate with two verbal prompts for three consecutive months by 4/20/08. See attachment #6	2-23-2008
W 232	483.440(c)(4)(iv) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be organized to reflect a developmental progression appropriate to the individual. This STANDARD is not met as evidenced by: Based on staff interview and record review, the	W 232		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 232	Continued From page 12 facility failed to ensure a client be afforded the opportunity to take part in a toileting program prior to being provided adult diapers. [Client #1] The finding includes: Interview with Staff #1 on 12/6/2007 at 2:25PM revealed Client #1 has a history of wetting her bed at night, but, this hasn ' t happened in a while. Staff #1 added that Client #1 has been waking up very frequently at night for various reasons. Record review revealed staff documented " urinary accidents " six times in 2006 between 10/2006 and 12/2006; and twice in 2/2007. The overnight staff (12-8am) have also been documenting that this client is waking up to shower quite frequently during their shift. Interview with the QMRP at 2:46pm reveals, she agrees that this client has been waking up at night and showering approximately 85% of the nights between 12/8/2006 and 12/6/2007, but there has been no inquiry into the nature of the " showers " . Note: on average, the records indicate this client is waking up and showering approximately 5-6 nights per week. Further record review revealed Client #1 ' s Urology assessment dated 2/8/2007 recommended that the facility " encourage [Client #1] to void every three (3) hours. The facility ' s QMRP indicated that this recommendation was never implemented, but the facility ' s director decided that this client should be provided with adult diapers to manage her nocturnal enuresis. There was no evidence presented or on file at the time of survey to substantiate that this client was provided the lesser restrictive treatment of toileting every three (3) hours prior to being provided the adult diapers.	W 232	The facility has implemented the recommendations of the urologist and is encouraging the person to void every three hours and is keeping a record as to whether or not she has voided, and under no circumstances are adult diapers being used. See attachment #7	2-23-2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure that clients receive interventions as specified in their behavior management plans for two of three sampled Clients. The findings include: 1. During evening observations on 12/4/2007, Client #1 was provided smaller portions than her housemates. She was also provided a small serving of yogurt and a bowl of fruit at the end of her meal. The other clients were not provided the yogurt. Interview with the facility ' s QMRP at 2:50pm revealed Client #1 was supposed to have the yogurt instead of the fruit. The QMRP then stated that she was not sure if she could have both. Record review on 12/6/2007 at 3:12pm revealed Client #2 ' s Nutritionist assessed her Ideal Body Weight (IBW) to be 111lbs to 148lbs. The assessment was completed on 3/6/07 and it further recommends: a. A diet change to 1500 kcal weight reduction, low cholesterol, low fat yogurt 1 cup at breakfast/or at dinner diet.	W 249	1. Staff have been trained on how to monitor and document the nutritional plan as recommended for individual # 1.	2-26-2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 14 b. Provide adequate hydration. c. Monitor food intake frequently. d. Monitor weight monthly. e. Attain and maintain weight within 10% of ideal body weight range. Further record review, with the assistance of the QMRP, revealed that there was no means available to substantiate that " adequate hydration " was being provided or that her food intake was being monitored. Interestingly, the provision and intake of the yogurt is being monitored and documented. Further record review revealed this client weight dropped from 180 to 178 between the months of 4/2007 and 7/2007 but, increased again to 183lbs between the months of 8/2007 and 11/2007. It is also important to note that this client ' s cholesterol level has been assessed to be 236 and there is also no means of assessing if this level is increasing or decreasing accordingly. There was no documentation on file or presented at the time of survey to substantiate that this client ' s nutritional plan has been followed as recommended. 2. Review of and assessment of the medications provided during med-pass revealed Client #2 ' s also receives 10mg of Oxybutymin CL ER daily for bladder control. Further record review revealed the following: a. Psychological Assessment dated 3/8/07 details to continue the " recommendations from the urology consultant ... to decrease incidents of nocturnal enuresis. " b. Urology assessment dated 2/8/2007 recommended that the facility " encourage [Client #1] to void every three (3) hours. "	W 249	2. See W232	2-23-2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 15 Interview with the facility ' s QMRP on 12/6/2007 at 2:17pm revealed, the treatment intervention made by the Urologist has not been implemented to date. As such, it is unclear why this client was provided adult diapers devoid of attempting this plan. [Reference W232] 3. Staff interview and record review on 12/4/2007 and 12/5/2007 revealed the facility failed to implement the proactive strategies outlined in Client #2 ' s 8/23/2007 Psychological assessment. [Reference W159]	W 249	3. See W232	2-23-2008
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure the implementation of an effective system of documenting the frequency of maladaptive behaviors as recommended in a Client ' s behavior management plan for two of three sampled Clients. [Client #1] The findings include: Observation at the facility and at Client #1 ' s day program on 12/4/2007 and 12/5/2007 revealed she requires consistent prompting to stay on task and appeared to tire quickly whenever engaged in any activity which required physical exertion. Review of Client #1 ' s programmatic record	W 252		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 252	Continued From page 16 revealed her Nutritional assessment dated 3/6/07 recommends that the facility manage Client #1 ' s weight via the following treatment plan: 1. Goal - " [Client #1] will improve her physical fitness skills " . 2. Objective 3a - " [Client #1] will exercise for thirty minutes by doing an activity that elevates her heart rate with 2 verbal prompts for three consecutive months. 3. Objective 3b - " [Client #1] will exercise for thirty minutes by doing an activity that elevates her heart rate with 1 verbal prompts for three consecutive months. Review of the data collection logs revealed Client #1 rode her stationary bike for 20 minutes on 12/1, 20 minutes on 12/2, 30 min on 12/3, 30 min on 12/4 and for 30 min on 12/5 of this year. Interview with the facility ' s QMRP on 12/6/2007 at 3:37pm revealed Client #1 is not the kind of person to stay focused on tasks and requires constant redirection. She also indicated that the data collection could have meant JB was involved for a total of 30 minutes over a period of time and not consecutively. Taking that implementation methodology in consideration, there was no evidence that this client engaged in the activity as required or long enough to produce an elevated heart rate as the program recommended. As such, this client ' s weight has been on the increase over the past few months and there is no way to assess the effectiveness of this written treatment intervention. [Reference W249]	W 252	See W230 #2	2-23-2008
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed	W 263		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 17 consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that programs which incorporate restrictive techniques and the use of medications to control behaviors were conducted only with the written informed consent of the client or legal guardian for two of the two sampled clients. [Clients #1 and #2] The findings include: 1. Client #1 was observed being administered 400mg of Tegretol (for mental condition), 2mg of Klonipin (for mental condition), 5mg of Risperdal (for Psychosis) and 450mg of Lithium Carbonate (for explosive behavior disorder). Record review revealed this client ' s medications were administered as prescribed based on the current physician ' s orders (12/2007) that were on file, but it was done so without the informed consent of an advocate. Interview with the facility ' s QMRP on 12/6/2007 at 1:56pm revealed that Client #1 ' s older sister has not taken part in agreeing to her sister being provided the medication regimen listed above. The facility has failed to ensure informed consent prior to implementing a pharmacological regimen to manage a client ' s maladaptive behavior. 2. Client #2 was observed being administered 400mg of Chlorpromazine HCL (for Psychotic Disorder) and 1mg Klopin (for Panic Attacks/Impulse Control). Record review revealed this client ' s medications were administered as prescribed based on the current	W 263	1. The facility has ensured written informed consent prior to implementing a pharmacological regimen to manage individual #1's maladaptive behavior. See attachment #8.	2-27-2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 18 physician ' s orders (12/2007) that were on file, but it was done so without the informed consent of an advocate. Interview with the facility ' s QMRP on 12/6/2007 at 2:00pm revealed that Client #2 has not been appointed a legal advocate to date. Further record review revealed that no one of an advocate status has provided informed consent on behalf of this client before implementing the medication regimen listed above. The facility has failed to ensure informed consent prior to implementing a pharmacological regimen to manage a client ' s maladaptive behavior.	W 263	2. The facility has ensured written informed consent prior to implementing a pharmacological regimen to manage individual #2's maladaptive behavior. See attachment #8.	2-27-2008
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the continued Urology care for one of two sampled clients. [Client #2] The finding includes: Review of and assessment of the medications provided during med-pass revealed Client #2 ' s also receives 10mg of Oxybutymin CL ER daily for bladder control. Client #1 ' s last completed Urology assessment was 2/8/2007. The facility attempted to secure her follow-up appointment on 10/15/07, but the client refused to attend the appointment. The next scheduled appointment was dated for 11/20/2007. There is no evidence that this appointment has been completed. It is not clear if the nursing staff was aware of this schedule change or not, but it is important to note	W 339	This person was seen by the urologist on 1/16/08, and the urologist recommended that she limit late fluid consumption.	2-23-2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 339	Continued From page 19 that this client has been waking up about 5 - 6 nights per week to shower. It is also not clear if these episodes are due to her nocturnal enuresis or not. [Reference W249]	W 339		
W 348	483.460(e)(1) DENTAL SERVICES The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the recommended dental follow-ups are required for two of two sampled clients. [Clients #1 & #2] The finding includes: 1. Observation on 12/4/2007 revealed Client #1 ' s teeth to be discolored. Record review revealed this client ' s Dental evaluation dated 12/4/2006 recommended " filling of #5 #6 (f), 37 (MILF), #25 (MILF), #26 (DF) and #27 (ML). Patient needs treatment under deep conscious sedation. " In addition, this client ' s Health management care plan identifies: a. Risk Area: " potential for poor oral hygiene/tooth decay, calculus, cavities. b. Risk management procedure: " brush teeth 2 -3x a day after meals and before bedtime. " c. Responsible staff: " DCS " . d. Training required: " yes " e. Oversight Scheduled: " ongoing " f. Oversight Staff: " Program Coordinator/Nursing " .	W 348	1. Staff have been trained on the importance of the individuals oral hygiene and documenting that individual #2 has brushed her teeth three times per day. See attachment # 9	2-26-2008

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 348	Continued From page 20 There was no evidence on file or presented at the time of survey to substantiate that these treatment recommendations had been completed. There was no evidence that this client received tooth brushing " 2-3x " a day and there was no evidence that the nursing staff had been monitoring of this client ' s oral health since the 12/4/2006 assessment. In addition, there is no evidence that this client has been afforded dental services over the past certification year. 2. Observation on 12/4/2007 revealed Client #2 ' s teeth were also discolored. Review of Client #2 ' s records revealed the following: a. Dental assessment dated 12/4/2006: recommended " filling of #5 + #6 (f), 37 (MILF), #25 (MILF), #26 (DF) and #27 (ML). Patient needs treatment under deep conscious sedation. Call in January to re-schedule. i. No evidence that the " fillings were ever completed " . b. Dental evaluation dated 2/21/07: recommended " cleaning, peroi eval, 2 filling #14, #29. No return appointment recommended. No evidence that the cleaning and fillings were completed. c. Dental evaluation dated 11/27/07: recommended " perio eval, deep scaling 4 quad, full x-ray, 2 filling on #2, #26. Return appointment 12/18/07. Further review of the records revealed none of the above treatments were completed. Interview with the facility ' s QMRP on 12/6/2007 at 1:30pm revealed she was not aware that these recommendations were not being followed. The QMRP also added that the dental provider was switched between the 12/4/2006 appointment and the 2/21/2007 appointment. With that being said, she also did not know if the dental history was	W 348	2. Client #2 has received dental care in the past survey year. See attachment #10.	2-23-2008

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 348	Continued From page 21 passed from the old dentist to the new. The facility failed to ensure the provision of consistent and aggressive dental services to manage a client ' s declining oral health.	W 348		
W 350	483.460(e)(3) DENTAL SERVICES The facility must provide education and training in the maintenance of oral health. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that client ' s received aggressive and consistent intervention to manage their declining oral health for two of two sampled clients. The finding includes: Both Clients #1 and #2 has been recommended for several extractions and fillings over the past certification year. Both have been recommended to receive tooth brushing " 2-3x daily ". Both client ' s oral health has not improved over the past year. In addition, there is no evidence that the facility has enacted measures to ensure their oral health does not get any worse. Interview with the facility ' s QMRP on 12/6/2007 at 1:30pm revealed she was not aware these recommendations were not being followed and she does not know if staff in monitoring and instructing the clients how to properly care for their oral health.	W 350	Staff have been trained on the importance of the individuals oral hygiene and documenting that individual #2 has brushed her teeth three times per day.	2-26-2008
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.	W 455		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 455	Continued From page 22 This STANDARD is not met as evidenced by: Based on observation staff interview and record review, the facility failed to ensure clients are provided with clean and sanitary clothing to wear. [Client #1] The finding includes: During the evening observation on 12/4/2007 and again on12/5/2007, Client #1 was observed wearing a quarter length dark colored overcoat. The front of this coat appeared to be soiled of either saliva, food or some other bodily fluid. She was allowed to wear this coat around the home and on her community outing on the evening of 12/4/2007. The facility failed to ensure this client was provided a clean coat to wear over the period of observation.	W 455	The House manager will be responsible for ensuring that all Staff have been trained on the importance on making sure that all individuals have on clean clothing.	2-26-2008
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients be allowed to eat with the proper eating utensils during meals for two of two sampled clients. [Client #1 & #2] The finding includes: During the evening observations on 12/4/2007, Clients #1 and #2 were observed eating their salad with a spoon. On several occasions during their dinner, the blades of lettuce would fall off the	W 488		

PRINTED: 02/13/2008
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	5634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 488	Continued From page 23 spoon and back into the salad bowl as they attempted to eat. With that problem, both clients resorted to occasionally using their hands to make sure they could eat their salad. Interview with the facility ' s QMRP on 12/6/2007 at 2:40pm revealed the clients were probably given spoons to eat their salad because Client #2 may have attempted to stab a staff ' s hand with a metal fork in times past. There was no evidence on file or presented during the survey to substantiate the claim nor was it recorded and demonstrated anywhere in the records that these clients were not able to manage eating their meals using a fork.	W 488	It is the policy of MarJul Homes that all individual eats with the proper utensils during all meals. Staff will inserviced on ensuring that all individuals are given proper utensils unless specified by the BSP.	2-26-2008

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS A licensure survey was conducted from 12/05/2007 through 12/06/2007. Three females with varying degrees of disabilities reside in the GHMRP. Two of the three residents were randomly selected for the survey sample. The findings of the survey were based on observations at the group home and day programs, interviews with staff and residents, and the review of records including the unusual incident reports.	I 000		
I 144	3506.1(e) PROGRAM STATEMENT Each GHMRP shall have a written statement of its philosophy and programmatic goals which shall include, at a minimum, the following: (e) The GHMRP ' s relationship with parents, advocates and legal guardians; and... This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to establish a philosophy or programmatic goals to ensure the provision of guardianship for one of three residents residing in the GHMRP. [Resident #2] The findings include: Staff interview on 12/6/2007 at 2:15pm revealed Resident #2 was without the services of a court appointed guardian. The Qualified Mental Retardation Professional (QMRP) indicated that the GHMRP has enacted measures to ensure this resident be provided the services of a court appointed guardian or advocate. There was no documentation on file or presented during the time of survey to substantiate that the GHMRP	I 144		

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 FEB 25 A 11:43

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 2-25-08

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 144	Continued From page 1 has taken the necessary proactive measures to provide this resident with either an advocate or a guardian. [Reference Federal Deficiency Report Citations W104 and W249]	I 144	See W104 #1 & W249	2-27-2008
I 162	3507.3 POLICIES AND PROCEDURES The manual shall be available for review and approval by District of Columbia personnel who have licensing, supervisory, monitoring and certification responsibility. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to ensure the provisions of this section as required. The finding includes: Record review on the afternoon of 12/6/2007 revealed the policy and procedures manual was not available for review. Interview with the Group Home for Mentally Retarded Persons (GHMRP) QMRP on 12/6/2007 at 1:58pm revealed she searched her records and was not able to provide the survey team with a copy of the corporate policy and procedures manual for an on-site review.	I 162	The QMRP and House Manager will ensure that a copy of the agency policy and procedure manual is kept on the premises at all times.	2-23-2008
I 169	3507.4(g) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (g) Resident life, which covers clothing, management of funds, resident rights, discipline, behavior management, services, parental and guardian involvement, visitation, staff treatment of residents, and resident work.	I 169		

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 169	Continued From page 2 This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure the provisions of this section as required for two of three residents residing in the GHMRP. [Resident #1 & #2] The finding includes: During the evening observations on 12/4/2007, staff indicated that Residents #1 and #2 were to take part in a shopping outing. They were to attend a local mall and make purchases for gifts to be given over the coming holidays. Interview with the GHMRP ' s QMRP on 12/5/2007 at 2:32pm revealed the GHMRP has accounts at a local bank under their names, but neither of them takes part in the depositing or withdrawal of their funds. According to the QMRP, the bank accounts are held under the GHMRP ' s name, but each resident ' s funds can be identified accordingly. There were no financial records available at the time of survey and as such, there was no means to ensure that each separate account accrued interest independently of each other per resident. [Reference Federal Deficiency Report - Citation W141] Record review on 12/6/2007 at 2:20pm revealed Resident #2 " eloped " from the GHMRP twice over the past certification year. Staff documented that this resident eloped twice on 2/27/07. The instances of elopement occurred at 4:36pm and again at 5:45pm on that same day. The first time she " eloped " from the GHMRP, she stood on the porch. The second time she " eloped " from the	I 169	See W141	2-23-2008

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 169	Continued From page 3 GHMRP; she went out to the street and sat on the sidewalk. As recorded, on both occasions, staff was able to coax her back into the home. The QMRP was interviewed on 12/6/2007 at 12:05pm and it was revealed that she was not aware Resident #2 had eloped earlier in the year. She further added that there should have been an incident report generated because of the recorded events of elopement. There was no evidence on file or presented at the time of survey to substantiate that these documented incidents of " elopement " were properly reported as required by this section. [Reference Federal Deficiency Report - Citation W153]	I 169	See W153	2-26-2008
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee had been provided with adequate training to enable them to perform their duties effectively, efficiently and competently. The findings include: Record review on 12/6/2007 at 2:20pm revealed Resident #2 " eloped " from the GHMRP twice over the past certification year. Staff documented that this resident eloped twice on 2/27/07. Record review also revealed that the attending Psychologist had addressed this need on 8/23/2007 by recommending a treatment strategy to prevent this resident ' s elopement. There was no evidence presented or on file at the time of survey to substantiate that the GHMRP ' s staff had been trained on how to manage, document	I 222		

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 222	Continued From page 4 and/or report this resident ' s elopement. [Reference Federal Deficiency Report - Citation W153]	I 222		
I 230	3510.5(g) STAFF TRAINING Each training program shall include, but not be limited to, the following: (g) Habilitation planning and implementation; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee had been provided with adequate training to enable them to perform their duties effectively, efficiently and competently. The findings include: Record review on 12/6/2007 at 2:20pm revealed Resident #2 " eloped " from the GHMRP twice over the past certification year. Staff documented that this resident eloped twice on 2/27/07. Record review also revealed that the attending Psychologist had addressed this need on 8/23/2007 by recommending a treatment strategy to prevent this resident ' s elopement. There was no evidence presented or on file at the time of survey to substantiate that the GHMRP ' s staff had been trained on how to manage, document and/or report this resident ' s elopement. [Reference Federal Deficiency Report - Citation W153]	I 230	See W153	2-26-2008
I 260	3512.1 RECORDKEEPING: GENERAL PROVISIONS Each Residence Director shall maintain current	I 260		

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 260	Continued From page 5 and accurate records and reports as required by this section. This Statute is not met as evidenced by: Based on staff interview and record review, the GHRMP failed to ensure that data collected and filed in resident records were maintained in an accurate manner to reflect current indicators of performance against the requirements of their behavior management plans for two of the three sampled residents. The findings include: Observation at the facility and at Resident #1 ' s day program on 12/4/2007 and 12/5/2007 revealed she requires consistent prompting to stay on task and appeared to tire quickly whenever engaged in any activity which required physical exertion. Review of Resident #1 ' s programmatic record revealed her Nutritional assessment dated 3/6/07 recommends that the facility manage Resident #1 ' s weight via the following treatment plan: 1. Goal - " [Resident #1] will improve her physical fitness skills " . 2. Objective 3a - " [Resident #1] will exercise for thirty minutes by doing an activity that elevates her heart rate with 2 verbal prompts for three consecutive months. " 3. Objective 3b - " [Resident #1] will exercise for thirty minutes by doing an activity that elevates her heart rate with 1 verbal prompts for three consecutive months. " Review of the data collection logs revealed Resident #1 rode her stationary bike for 20	I 260		

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 260	Continued From page 6 minutes on 12/1, 20 minutes on 12/2, 30 min on 12/3, 30 min on 12/4, and for 30 min on 12/5 of this year. Interview with the facility ' s QMRP on 12/6/2007 at 3:37pm revealed Resident #1 is not the kind of person to stay focused on tasks and requires constant redirection. She also indicated that the data collection could have meant JB was involved for a total of 30 minutes over a period of time and not consecutively. Taking that implementation methodology in consideration, there was no evidence that this resident engaged in the activity as required or long enough to produce an elevated heart rate as the program recommended. As such, this resident ' s weight has been on the increase over the past few months and there is no way to assess the effectiveness of this written treatment intervention.	I 260	See W230 #2	2-23-2008
I 392	3520.2(b) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (b) Dentistry; This Statute is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the recommended dental follow-ups are required for two of two sampled	I 392		

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 392	Continued From page 7 residents. [Residents #1 & #2] The finding includes: 1. Observation on 12/4/2007 revealed Resident #1's teeth to be discolored. Record review revealed this resident ' s Dental evaluation dated 12/4/2006 recommended " filling of #5 #6 (f), 37 (MILF), #25 (MILF), #26 (DF) and #27 (ML). Patient needs treatment under deep conscious sedation. " In addition, this resident ' s Health management care plan identifies: a. Risk Area: " potential for poor oral hygiene/tooth decay, calculus, cavities. b. Risk management procedure: " brush teeth 2 -3x a day after meals and before bedtime. " c. Responsible staff: " DCS " . d. Training required: " yes " e. Oversight Scheduled: " ongoing " f. Oversight Staff: " Program Coordinator/Nursing " There was no evidence on file or presented at the time of survey to substantiate that these treatment recommendations had been completed. There was no evidence that this resident received tooth brushing " 2-3x " a day and there was no evidence that the nursing staff had been monitoring of this resident ' s oral health since the 12/4/2006 assessment. In addition, there is no evidence that this resident has been afforded dental services over the past certification year.	I 392		

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 392	Continued From page 8 2. Observation on 12/4/2007 revealed Resident #2's teeth were also discolored. Review of Resident #2' s records revealed the following: a. Dental assessment dated 12/4/2006: recommended " filling of #5 + #6 (f), 37 (MILF), #25 (MILF), #26 (DF) and #27 (ML). Patient needs treatment under deep conscious sedation. Call in January to re-schedule. " b. Dental evaluation dated 2/21/07 recommended " cleaning, perio eval, 2 filling #14, #29. No return appointment recommended. No evidence that the cleaning and fillings were completed. " c. Dental evaluation dated 11/27/07 recommended " perio eval, deep scaling 4 quad, full x-ray, 2 filling on #2, #26. Return appointment - 12/18/07. " Further review of the records revealed none of the above treatments were completed. Interview with the facility ' s QMRP on 12/6/2007 at 1:30pm revealed she was not aware that these recommendations were not being followed. The QMRP also added that the dental provider was switched between the 12/4/2006 appointment and the 2/21/2007 appointment. With that being said, she also did not know if the dental history was passed from the old dentist to the new. The facility failed to ensure the provision of consistent and aggressive dental services to manage a resident ' s declining oral health. Note: There was no evidence presented or on file at the time of survey to substantiate that the treatment recommendations from the 12/4/2006 and the 2/21/2007 consults were completed.	I 392	See W348	2-23-2008

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 9	I 422		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review the GHMRP failed to ensure that residents receive interventions as specified in their behavior management plans for two of three sampled Residents. The findings include: 1. During evening observations on 12/4/2007, Resident #1 was provided smaller portions than her housemates. She was also provided a small serving of yogurt and a bowl of fruit at the end of her meal. The other residents were not provided the yogurt. Interview with the GHMRP's QMRP at 2:50pm revealed Resident #1 was supposed to have the yogurt instead of the fruit. The QMRP then stated that she was not sure if she could have both. Record review on 12/6/2007 at 3:12pm revealed Resident #2 ' s Nutritionist assessed her Ideal Body Weight (IBW) to be 111lbs to 148lbs. The assessment was completed on 3/6/07 and it further recommends: a. A diet change to 1500 kcal weight reduction, low cholesterol, low fat yogurt 1 cup at breakfast/or at dinner diet. b. Provide adequate hydration. c. Monitor food intake frequently. d. Monitor weight monthly. e. Attain and maintain weight within 10% of ideal body weight range. Further record review, with the assistance of the	I 422	1. See W240	2-26-2008

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 10 QMRP, revealed that there was no means available to substantiate that " adequate hydration " was being provided or that her food intake was being monitored. Interestingly, the provision and intake of the yogurt is being monitored and documented. Further record review revealed this resident weight dropped from 180 to 178 between the months of 4/2007 and 7/2007 but, increased again to 183lbs between the months of 8/2007 and 11/2007. It is also important to note that this resident ' s cholesterol level has been assessed to be 236 and there is also no means of assessing if this level is increasing or decreasing accordingly. There was no documentation on file or presented at the time of survey to substantiate that this resident ' s nutritional plan has been followed as recommended. [Reference Federal Deficiency Report - Citation W249] 2. Review of and assessment of the medications provided during med-pass revealed Resident #2 ' s also receives 10mg of Oxybutymin CL ER daily for bladder control. Further record review revealed the following: a. Psychological Assessment dated 3/8/07 details to continue the " recommendations from the urology consultant ... to decrease incidents of nocturnal enuresis. " b. Urology assessment dated 2/8/2007 recommended that the Group Home for Mentally Retarded Persons (GHMRP) " encourage [Resident #1] to void every three (3) hours. " Interview with the facility ' s QMRP on 12/6/2007 at 2:17pm revealed, the treatment intervention made by the Urologist has not been implemented to date. As such, it is unclear why this resident was provided adult diapers devoid of attempting	I 422	2. See W232	2-23-2008

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 11 this plan. [Reference W232] 3. During afternoon and evening observations on both 12/4/2007 and 12/5/2007, Resident #2 was observed to independently manage her chores after staff prompted her to initiate each task. The various assignments took place at different parts of the house, on different floors, and oftentimes out of sight. Record review on 12/6/2007 at 2:20pm revealed Resident #2 " eloped " from the facility twice over the past certification year. Staff documented that this resident eloped twice on 2/27/07. Further record review revealed Resident #2 ' s Psychology Assessment dated 8/23/2007 addressed her potential to elope with the following treatment recommendations: a. Goal: [Resident #2] will decrease episodes of elopement to zero incidents per month. b. Intervention Strategies: " address elopement before it occurs by making certain that [Resident #2] is supervised by staff at all times. If [Resident #2] is successful in leaving her group home or other assigned area, staff should calmly pursue her (calmly, as to prevent further agitation) and ask her to return with them. If [Resident #2] refuses, staff should use approved physical control techniques of CPI designed to escort a person from one location to another. If the situation continues to escalate, staff should call other [Provider] staff or the police for assistance. This resident ' s Psychiatric Assessment dated 9/13/07 further recommends: i. Continue to implement behavior support plan. Continue to emphasize following the proactive strategies outlined in the behavior program to avoid behaviors before they occur.	I 422	3. See W189	2-23-2008

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 422	Continued From page 12 ii. Continue to monitor [maladaptive] behaviors. Further interview with the facility ' s Qualified Mental Retardation Professional (QMRP) revealed she was not certain what the Psychologist meant when she recommended Resident #2 remain in her " assigned area " . In addition, she stated this resident ' s one-to-one staffing was discontinued, but was not aware the psychologist had recommended this resident be " supervised by staff at all times " and that staff should " pursue her " if she leaves her " assigned area " . There was no evidence presented or on file at the time of survey to substantiate that the necessary coordination of services was implemented to address this resident's potential to elope.	I 422		
I 429	3521.6 HABILITATION AND TRAINING Each GHMRP Director shall arrange for each resident to be reevaluated and to receive an Individual Habilitation Plan, which is updated appropriately at least annually. This Statute is not met as evidenced by: Based on staff interview and record review, the GHMRP failed to accurately assess a resident ' s potential to attempt suicide. The finding includes: While reviewing how the GHMRP managed Resident #2 ' s episodes of elopement on the afternoon of 12/6/2007, it was found that Resident #2 ' s Psychiatric assessment dated 9/13/2007 resolved that the GHMRP should " Implement Reintegration Plan and Suicide Behavior Protocol when needed " . A secondary	I 429		

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6834 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 429	Continued From page 13 review of the records with the QMRP ' s assistance revealed that there was no other instance of recording that this resident was a suicide risk. It was also not clear how or why the Psychiatrist indicated as such. It was also not clear what the " Reintegration Plan and Suicide Behavior Protocol " entailed. The actual plan could not be located anywhere In this resident ' s records. The QMRP indicated that she will address this finding to ensure the health and safety of this resident. [Reference Federal Deficiency Report Citation - W249]	I 429	The psychological assessment does recommend the implementation of the suicide behavior protocol which is filed in the individuals IPP book and it is recommended bythe psychologist to be implemented as needed.	2-28-2008
I 443	3521.7(m) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (m) Financial management (including budgeting and banking); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that resident ' s were afforded the opportunity to take part in managing their finances as required by this section. [Residents #1 & #2] The finding includes: During the evening observations on 12/4/2007, staff indicated that Residents #1 and #2 were to take part in a shopping outing. They were to attend a local mall and make purchases for gifts to be given over the coming holidays. Interview with the GHMRP ' s QMRP on 12/5/2007 at 2:32pm revealed the GHMRP has accounts at a local bank under their names, but neither of them takes part in the depositing or withdrawal of their	I 443		

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 443	Continued From page 14 funds. According to the QMRP, the House Manager procures the funds from the GHMRP ' s President/Owner after he withdraws the money from the resident ' s accounts. Record review revealed neither Resident #1 nor Resident #2 had been assessed to determine their level of ability with regards to money management. There was no evidence on file or presented at the time of survey to substantiate that both resident ' s was provided the opportunity to manage their finances to the best of their ability.	I 443	See W126	2-23-2008
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to ensure the provisions of this section as required for two of three residents residing in the GHMRP. [Resident #1 & #2] The findings include: 1. Resident #1 was observed being administered 400mg of Tegretol (for mental condition), 2mg of Klonipin (for mental condition), 5mg of Risperdal (for Psychosis) and 450mg of Lithium Carbonate (for explosive behavior disorder). Record review revealed this resident ' s medications were administered as prescribed based on the current physician ' s orders (12/2007) that were on file. Interview with the GHMRP ' s QMRP on 12/6/2007 at 1:56pm	I 500		

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6534 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 15 revealed that Resident #1 ' s older sister has been actively involved in her care ever since she was committed. Further record review revealed, Resident #1 ' s sister signed the " Informed Consent for Psychotropic Medication and Behavior Support " agreement, but there is no evidence that she took part in the Psychotropic Medication Review which was held on 11/29/2007 or the Human Rights Committee meeting to address the implementation of Resident #1 ' s Behavior Support Plan. [Reference Federal Deficiency Report Citation W124]	I 500	1. See W124 #1	2-23-2008
	2. Resident #2 was observed being administered 400mg of Chlorpromazine HCL (for Psychotic Disorder) and 1mg Klopin (for Panic Attacks/Impulse Control). Record review revealed this resident ' s medications were administered as prescribed based on the current physician ' s orders (12/2007) that were on file. Interview with the GHMRP ' s QMRP on 12/6/2007 at 2:00pm revealed that Resident #2 has not been appointed a legal advocate to date. Further record review revealed that no one stood as either a legally appointed guardian or advocate during the psychotropic medication review or the Human Rights Committee meeting to address the implementation of her Behavior Support Plan. [Reference Federal Deficiency Report Citation W124]		2. See W104 #1	2-27-2008
	3. During the evening observations on 12/4/2007, staff indicated that Residents #1 and #2 were to take part in a shopping outing. They were to attend a local mall and make purchases for gifts to be given over the coming holidays. Interview with the GHMRP ' s QMRP on 12/5/2007 at 2:32pm revealed the GHMRP has accounts at a local bank under their names, but neither of them takes part in the depositing or		3. See W126	2-23-2008

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G154	A. BUILDING _____ B. WING _____	12/05/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARJUL HOMES	6634 EASTERN AVENUE, NW WASHINGTON, DC 20012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 500	Continued From page 16 withdrawal of their funds. According to the QMRP, the House Manager procures the funds from the GHMRP ' s President/Owner after he withdraws the money from the resident ' s accounts. Record review revealed neither Resident #1 nor Resident #2 had been assessed to determine their level of ability with regards to money management. There was no evidence on file or presented at the time of survey to substantiate that both resident ' s had a been provided the opportunity to manage their finances to the best of their ability.	I 500		